Utilization Management Department/Commercial and Medicare

Utilization management is the use of managed care techniques such as prior authorizations that allow health insurance companies to manage the cost of health care benefits by assessing its appropriateness before it is provided using evidence-based criteria or guidelines. Santé UM Department consists of Authorization Coordinators, Nurses and Doctors.

Authorizations should be submitted using the Quick Cap Provider Portal. Authorization status inquiries can be obtained using the Quick Cap Provider Portal. The portal can be accessed using the following link:

https://www.santephysicians.com/

Portal Issues can be reported to portalsupport@santehealth.net

Services Requiring Prior Authorization

- Bariatric Surgery
- Colonoscopy; EGD; Manometry
- Cosmetic/Reconstructive Surgery
- Durable Medical Equipment purchases over $500 (Per line item)
- Durable Medical Equipment (All rentals, regardless of cost)
- Genetic Testing
- Home Health
- Home Infusion
- Infusions – Ambulatory
- Injections: Self–injectables
- Injections: In-office injectables
- MRI, MRA, CT and Pet scans
- Out of Plan Provider
- Sleep Studies
- Transplants (In conjunction with Health Plan programs)
- Varicose Vein Treatment
- Wound Care – Facility Based

UM Department Turn-around Times

- **Routine requests** – when received with all required documentation, a routine request will be decided **within 5 business days**.
- **Expedited requests** – when received with all required documentation, an expedited request may be decided **as soon as 24 hours and no later than 72 hours**.

An expedited request should only be submitted in situations that are considered time sensitive. A time sensitive situation is defined as any situation in which waiting for the standard decision making process could result in seriously jeopardizing the member's life, health, or the ability to regain maximum function. Examples of time sensitive situations include but are not limited to severe pain and potential

loss of life, limb, or major bodily function. **Scheduling matters are not reason for urgent submission.**

The following are situations & conditions where the above urgent criterion does not apply:

- Elective procedures
- DME for pre-existing conditions
- Injectable drugs for chronic conditions
- Advanced imaging for chronic conditions
- Specialty Referrals for chronic conditions
- Mobility Treatment/Devices
- Hearing Aids
- Sleep Studies
- Cranial Orthoses

To ensure our members are properly cared for, please follow the guidelines below when submitting your request:

- Check benefits and eligibility with the health plan
- Authorization form should be completed in full with all required fields
- All requests require clinical documentation to determine medical necessity
- Do not schedule appointments prior to authorization approval – we do not review for retroactive services

Santé Physicians Utilization Management department utilizes a hierarchy of criteria when making coverage determinations for each line of business. Depending on line of business, the following criteria may be used.

1. Eligibility and benefits (Evidence of Coverage)
2. State-specific and Federal guidelines or mandates
3. Health Plan Guidelines and Benefit Interpretation Policies
4. InterQual, Adult and Pediatric
5. Apollo Managed Care Guidelines
6. AIM Clinical Appropriateness Guidelines
7. National Comprehensive Cancer Network
8. Medical Group/IPA Policy
9. CMS Criteria (NCD, LCD, LCA, MBPM)

Prior authorization requests are reviewed by clinical and medical staff such as doctors and nurses. To meet state and national standards, the reviewer uses current clinical guidelines to decide if the request is medically necessary. When a prior authorization request is authorized, modified, or denied a copy of the guideline, protocol or other similar criteria, on which the decision was based, can be requested, by calling Santé Community Physicians at (559) 228-2905 or at the following Health Plan's websites:

Aetna https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html
Anthem Blue Cross https://www.anthem.com/ca/provider/policies/clinical-guidelines/
Blue Shield https://www.blueshieldca.com/provider/authorizations/clinical-policies/medical-procedures/policy.sp
Cigna https://static.cigna.com/assets/chcp/resourceLibrary/coveragePolicies/index.html
Health Net https://www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/medical_policies.html
United Healthcarehttps://www.uhcprovider.com/en/policies-protocols.html
CMS: https://www.cms.gov/medicare-coverage-database/new-search/search.aspx
AIM: https://aimspecialtyhealth.com/resources/clinical-guidelines/

If your request is approved, you will be notified of the approval via fax. This notice includes the member's information and authorization information such as the authorization number, valid dates, and the services approved. In some instances, you will need to forward this letter to the provider of services when applicable (DME vendor, hospital, specialist, etc.). A letter of approval will also be mailed to the member.

If your request is modified or denied, the provider will receive a copy of the member's notification letter via fax. This notice includes the member's information, authorization information, as well as listing the name and contact information for the practitioner responsible for this decision. The determination letter will be mailed to the member and includes important information such as their appeal rights if they do not agree with our decision.

Common UM Denials

- Cosmetic
- Not a plan benefit
- Inadequate medical justification
- Conservative treatment or required imaging (x-ray) prior to Complex Imaging requests
- Incomplete notes or lack of documentation
- Services can be provided by an in-plan provider
- Failure to see an in plan specialist prior to requesting OON
- Alternate service recommended
- Does not comply with UM guidelines

Clinical Appeals

Members can appeal their authorization denial by submitting an appeal to their health plan. Their appeal rights and instructions including the mailing address and telephone number are included in the member denial letter.

Providers can submit an appeal to the member's health plan on the member's behalf, or call the Santé Chief Medical Officer to request a Peer to Peer at (559) 228-4455.

To request an appeal by telephone or in writing contact the Health Plan at the following locations:

Aetna Health of California, Inc.
Attn: Customer Resolution Team
P.O. Box 20430
Fresno, CA 93779
Telephone: 1-800-756-7039
Expedited 1-877-628-6736
Internet: www.aetna.com

Aetna Medicare
Part C Appeals and Grievances
P.O. Box 14067
Lexington, KY 40512
Toll Free: 1-800-932-2159
Fax: 1-724-741-4953
Fast Appeal 1-800-932-2159
Internet: www.aetnamedicare.com

Anthem Blue Cross
Attn: Grievance & Appeals Department
P.O. Box 4310
Woodland Hills, CA 91365-4310
Telephone: 1-800-365-0609
Fax: 1-818-234-1089
Internet: www.bluecrossca.com

Blue Shield of California
Attn: Member Appeals and Grievances
P.O. Box 5588
El Dorado Hills, CA 95762-0011
Telephone: 1-800-393-6130
Fax: 1-916-350-7585
Internet: www.mylifepath.com

Blue Shield 65 Plus HMO
Appeals & Grievances Department
P.O. Box 927
Woodland Hills, CA 91365-9856
Telephone: 1-800-776-4466
Fax: 1-916-350-6510
Internet:

Brand New Day
Appeal and Grievance Dept.
5455 Garden Grove Blvd., 5th Floor
Westminster, CA 92683
Telephone: 1-866-255-4795
Fax: 1-657-400-1217
TTY/TDD: 1-866-321-5955

CIGNA Health Care
National Appeals Organization
P.O. Box 188011
Chattanooga, TN 37422
Telephone: 1-800-244-6224
Fax: 1-877-815-4827
Internet: www.cigna.com

Health Net of California, Inc.
Member Services Appeals & Grievances
P.O. Box 10348
Van Nuys, CA 91410-0348
Phone: 1-800-522-0088
Fax: 1-877-831-6019
Internet: www.healthnet.com

Wellcare by Health Net of California, Inc.
Medicare Appeals & Grievances
P.O. Box 10450
Van Nuys, CA 91410-0450
Phone: 1-800-275-4737
Fax: 1-844-273-2671

United Healthcare
Attn: Appeals & Grievances Unit
Mail Stop CA 124-0160
P.O. Box 6107
Cypress, CA 90630-9972
Telephone: 1-800-624-8822
Fax: 1-866-704-3420
Internet: www.unitedhealthcare.com

Referrals

Primary Care Physicians (PCPs) act as care managers of their patients' health and are responsible for ensuring that their patients in need of medical care beyond their scope of practice are referred to appropriate Specialist Physicians, designated services or providers. Referral forms are available to be used by PCPs when directing patients to these providers.

This policy will not apply in situations where patients are seen on an emergent basis or when utilizing one of the self-referring options. Referrals written after a service has been performed will not be honored.

Referral Process

A referral form template is provided to each PCP office to refer Santé HMO members to a specialist. The PCP may use the template provided by Santé or use his/her own referral form. If the PCP opts to use his/her own referral form, the referral form must contain, at a minimum, all information contained in the Santé referral form template. Referrals can also be sent electronically using EPIC.

Complete a referral form in its entirety when referring to an in-plan physician specialist, designated service or provider. (Do not complete a referral form for routine services, such as x-rays or lab work.) Referrals must include dates, diagnoses and diagnosis codes. Fax or mail a copy of the referral form to the Specialist Provider.

NOTES:

Please contact Utilization Management for authorization of any non-plan provider. This ensures benefit compliance, use of contracted facilities, and negotiation of rates. DO NOT FILL OUT A REFERRAL FORM to a non-plan provider. This will obligate Santé to pay at non-plan rates, and the referring physician will be monetarily penalized.

Non-authorized elective services rendered by a non-plan provider, as a result of a Santé contracted physician referral, shall be approved for payment according to the following protocol:

- Services will be paid to the non-plan provider at non-plan rates.
- The referring Santé physician's future reimbursements will be debited the amount equal to the difference between payment made to the non-plan provider and the Santé contract reimbursement rate, not to exceed $1000 for each unauthorized referral.
- Self-referral options are the only exception.

Self-Referrals OBGYN Services

An HMO female member has the option of seeking obstetrical and gynecological physician services directly from a Santé OB/GYN or from a participating family practice physician, surgeon, or internist designated as providing OB/GYN services. Additionally, self-referral patient information must be communicated back to the patient's PCP of record. This includes:

- OB/GYN preventive care
- Pregnancy
- Gynecological complaint

OB/GYNs and other specialists treating a Santé HMO patient under this policy must remember to mark SELF-REFERRAL in box 19 of your HCFA form in lieu of submitting a Santé referral number and form.

Medicare members Self-Referral

Brand New Day

Members who wish to self-refer will call directly to Brand New Day member services. Brand New Day will complete a Santé prior authorization form with all the pertinent information and fax to Santé UM. Brand New Day will indicate on the form "Member Self-Referral"

Santé UM will treat the request as if received by the provider and the request will process the request accordingly.

HMO Commercial Plans with Self-Referral Options

Blue Shield

All Blue Shield HMO members may participate in the *Blue Shield Access +* enhancement. This enhancement allows the patient to self-refer to a Santé Specialist Physician or PCP, other than assigned PCP. Services included:

- Basic examinations/consultations/routine office based diagnostic and/or treatment procedures performed during the Access + visit
- Conventional x-rays (excluding diagnostic imaging, MRI, CT or bone density measurement) and laboratory services that may be provided in thephysician's office or by Santé contracted radiology or lab providers
- Self-Referral copay is collected
- Send these claims to Santé, indicating Access + Benefit in field #19 on the HCFA 1500 form
- Patient must present both the Blue Shield HMO ID Card and the Access+ Specialist Card

Anthem Blue Cross

All Anthem Blue Cross HMO Members may participate in the ***Direct Access*** enhancement. This enhancement allows the patient to self-refer to a Santé Specialist Physician in the following areas only:

- Allergy
- Dermatology
- Ear, Nose & Throat
- Obstetrics/Gynecology

Services included

- Medically necessary services that can be done in the Specialist's Office. Any care needed outside the Specialist's office must be coordinated through the PCP
- Normal copay is collected
- Number of visits are not limited
- Send these claims to Santé, indicating Direct Access in field #19 on the HCFA 1500 form
- No changes on Anthem Blue Cross ID Card
- Anthem Blue Cross POS plans offer this enhancement as well

Behavioral Health

A referral from the Primary Care Physician is not necessary for members to access Behavioral Health Services. The provider office can direct the member to contact the behavioral health administrators at the following numbers: *(Please keep in mind that the PCP may also contact the administrator)*

Aetna Commercial	Contact "Aetna Member Services" number listed on the Back of patient ID card and request assistance with a behavioral health referral
Aetna Senior	BBMC (559) 437-1111
Anthem Blue Cross Commercial Behavioral Health Plan	1-800-677-6669
Blue Shield Commercial Magellan	1-877-263-9952
Blue Shield Senior	BBMC (559) 437-1111
Brand New Day	BBMC (559) 437-1111
Cigna	Check Member ID Card – Carve out providers vary
Wellcare by Health Net (Commercial & Medicare) Managed Health Network	For urgent or emergent referrals: 888-426-0030 Self-referrals: call phone number on back of ID card
United HealthCare Commercial	Optum Behavioral Health at 800-999-9585
United HealthCare Medicare	BBMC (559) 437-1111